

# Obstetrics and Gynecology: Considerations in Career Selection

EDMUND STEPHEN PETRILLI, MD, *Washington, DC*

*Current training programs in obstetrics and gynecology are not producing an excess of specialists in view of future manpower needs. In addition to being specialists and consultants, obstetrician-gynecologists also function as providers of primary care for women. During the last decade, three formal subspecialties of obstetrics and gynecology have evolved: gynecologic oncology, maternal-fetal medicine and reproductive endocrinology. These have improved patient care and have altered the structure of resident education. With more American medical school graduates entering this specialty, the quality of resident applicants has improved, creating intense competition for desirable training positions. Those inclined toward a career in obstetrics and gynecology can be assured that it will provide an increasingly favorable and challenging environment for professional activity in the future.*

FOR MANY MEDICAL STUDENTS, rewarding experiences during clinical clerkships result in attraction to particular areas of medicine and often form the basis for subsequent career selection. After personal interests are identified, students often consider issues that may affect them in the training and practice of a particular specialty. This report addresses some of the questions frequently asked by interested students regarding the present and future direction of obstetrics and gynecology. General influences include medical manpower requirements, distribution of physicians and ratios of specialists to generalists. More specific con-

cerns involve the changing nature of specialty practice in obstetrics and gynecology, and the adequacy of current resident education to meet future needs. These considerations are important to all involved in the health care of women.

## Manpower Requirements

The 78th Annual Report on Medical Education of the *Journal of the American Medical Association* provides an extensive analysis of the past, present and future status of medical manpower.<sup>1</sup> Between 1960 and 1977 the number of medical students graduating annually doubled from 7,000 to 14,000 and medical schools increased from 86 to 124 in response to the need for more doctors in the United States. The growth rate of new physicians, five times higher than that of the general population, has since begun to decline

From the Department of Obstetrics and Gynecology, UCLA Center for the Health Sciences, Los Angeles. Dr. Petrilli is now affiliated with Georgetown University Hospital in Washington, DC. Submitted, revised, June 23, 1980.

Reprint requests to: Edmund S. Petrilli, MD, Department of Obstetrics and Gynecology, Georgetown University Hospital, 3800 Reservoir Rd., N.W., Washington, DC 20007.

and will stabilize in the 1980's with 16,000 to 17,000 graduates each year. There were 437,000 physicians in this country at the end of 1977, of which 192,629 held specialty certificates—including 14,199 in obstetrics and gynecology. The lack of adequate health care services that persists for certain segments of the population is no longer due to an insufficient number of physicians. Such deficiencies exist because of an imbalance in the proportion of specialists to generalists, and poor geographical distribution of physicians in relation to health care needs.<sup>2</sup> The goal of having at least 50 percent of all medical graduates train in areas of primary care is being successfully reached, given the stimulus of government support. Inadequate distribution of physicians continues to occur in rural and inner city locations, however, where the lowest physician to patient ratios exist. Finding a solution to this problem may be more difficult than altering the ratio of specialists to generalists.

There is some concern that more physicians are being trained in obstetrics and gynecology than will be needed in 10 or 20 years. This is unlikely, however, because it has been projected that 32,000 to 40,000 such specialists will be needed by 1990 when the estimated supply will not exceed 32,000.<sup>3</sup> The demand for services may increase at a faster rate than the population because it is expected that more people will participate in the health care system in the future. Thus, the subsequent demand for obstetric-gynecologic care could exceed available resources despite a projected increase in the ratio of specialists to the population. For example, although the birth rate has declined, obstetricians are now responsible for 81 percent of all deliveries in comparison to only 68 percent a decade ago as a result of decreasing participation by general practitioners.<sup>4</sup> This suggests that the potential work load for each obstetrician should at least remain stable in the future barring unexpected changes in projected birth rates. Other areas of patient care involving family planning, cancer screening and minor gynecologic problems will require more sharing of responsibility in the future. Generalists, internists and nurse practitioners could also provide this care, particularly in rural or inner city locations, if demands reach the higher range of projections. However, it is unlikely that the number of trained obstetrician-gynecologists will exceed the needs of this country during the next 20 years.

### Nature of the Specialty

There has been controversy regarding the nature of the health care provided by obstetrics and gynecology. In addition to providing specialized medical services, it is also a unique source of primary care for women. Willson and Burkons<sup>5</sup> found that 86 percent of women surveyed visited no physician other than their obstetrician-gynecologist on a routine basis; 25 percent had conditions diagnosed that were unrelated to the specialty. Fifty percent of the responding doctors commonly treated health problems unrelated to obstetrics and gynecology. This dual form of care appears to be rewarding to these practitioners. Wechsler and co-workers<sup>6</sup> reported that 74 percent of obstetrician-gynecologists practice their specialty at least half-time, ten years after the completion of training, in comparison to 56 percent of pediatricians and 28 percent of internists.

During the past decade three areas of formal subspecialization have evolved within obstetrics and gynecology in an attempt to incorporate rapid scientific progress and to provide optimal training, research and patient care. These are gynecologic oncology, maternal-fetal medicine and reproductive endocrinology. Approximately 2 percent of obstetrician-gynecologists have subspecialty certification at present, compared with 35 percent of internists.<sup>7</sup> It is estimated that the needs of society could be met if 10 percent of all obstetrician-gynecologists were certified subspecialists.<sup>8</sup> The desired representation in maternal-fetal medicine and reproductive endocrinology may not be reached in the foreseeable future. Referral centers, which are responsible for teaching, research and patient care have the greatest need for certified subspecialists. Subspecialty divisions within departments of obstetrics and gynecology have effected changes in the structure and content of residency programs, resulting in a more concentrated approach to the treatment of patients with complicated diseases. Whether or not this advantage compensates for the shift of some degree of resident responsibility to the fellowship level is controversial. One example of this influence on subsequent patterns of practice is that recent graduates of residency programs tend to refer more complex clinical problems to tertiary centers than practitioners who completed training before the era of formal subspecialization.<sup>9</sup> The

central issue in such matters is the recognized obligation to deliver optimal care to women with special health problems, rather than where or by whom this care is provided.

### Resident Education

The number of training positions in obstetrics and gynecology has remained fairly constant over the last decade and about 7 percent of American medical school graduates continue to enter the specialty each year.<sup>10</sup> In 1977-1978 there were over 4,000 residents training in obstetrics and gynecology. In recent years about 30 percent of new house officers have been women, which reflects their increasing representation in medical schools rather than a disproportionate interest in the specialty.<sup>11</sup> The increasing number of American graduates entering residency programs has resulted in the acceptance of fewer graduates of foreign medical schools and greater competition for the available training positions (personal communication, February 1979, Council on Resident Education in Obstetrics and Gynecology Data Bank, One East Wacker, Chicago, IL 60601).

Willson and Burkons<sup>9</sup> found that 72 percent of the specialists trained in university programs considered themselves well prepared for practice in comparison to only 45 percent of those trained in community hospitals. The failure rates on both the written and oral parts of the American Board specialty examination are higher for the latter group. Good community hospitals may need to become more closely affiliated with university centers to strengthen their training capabilities and marginal educational programs may deteriorate further and cease to function. University and affiliated programs, maintaining a higher quality of education than exists elsewhere at present, could efficiently meet future training needs as they occur. This projection is in keeping with the recent emphasis on regionalized patterns of care. University departments will also be expected to provide additional training for residents in family practice programs. These physicians will be needed in the future to provide the ambulatory services beyond those that can be delivered by obstetrician-gynecologists.

Traditionally, training programs have stressed the specialist-consultant aspects of obstetrics and gynecology. Some suggest that the realities of practice demand more educational exposure to other primary care disciplines.<sup>9</sup> Additional core

experience in abdominal and pelvic surgical procedures is advocated by others.<sup>12</sup> An eventual restructuring of the basic residency program could be forthcoming as a result of these considerations.

In 1978 there were 188 applications for residency submitted to the Department of Obstetrics and Gynecology at the University of California, Los Angeles; 120 candidates were interviewed. Six positions were filled from within the first 20 applicants listed with the National Interns and Residents Matching Program. The criteria used in resident selection included National Board examination scores, academic honors, letters of recommendation and personal interviews. Many educators hold the opinion that the quality of resident applicants has improved substantially in recent years, however, the deletion of standard objective criteria such as grades and class rank makes this impression difficult to quantitate.<sup>7,10,11</sup>

When questioned about their choice of obstetrics and gynecology as a career, most candidates related an interest in the combination of specialized medical and surgical skills and the opportunity to provide primary and continuing patient care. This is consistent with the dual practice role of obstetrician-gynecologists and correlates with subsequent career satisfaction. Many persons are attracted to the exciting research horizons offered by the subspecialties in obstetrics and gynecology, which have become highly competitive with other areas of medicine. A favorable and challenging professional environment can be expected by those considering future careers in this specialty.

### REFERENCES

1. The 78th Annual Report on Medical Education in the United States. JAMA 240:2810-2814, 1978
2. Wechsler H: Selecting a specialty. New Physician 25:41-43, May 1976
3. Peckham BM: Resident training goals in obstetrics and gynecology for the 1980's. Am J Obstet Gynecol 132:709-716, 1978
4. Pearse WH: Who delivers babies (Editorial). ACOG Newsletter 23:3, May 1979
5. Willson JR, Burkons DM: Obstetrician-gynecologists are primary physicians to women—I. Practice patterns of Michigan obstetrician-gynecologists. Am J Obstet Gynecol 126:627-632, 1976
6. Wechsler H, Dorsey J, Bovey JD: A follow-up study of residents in internal medicine, pediatrics and obstetrics-gynecology training programs in Massachusetts. N Engl J Med 298:15-21, 1978
7. Pearse WH, Trabin JR: Subspecialization in obstetrics and gynecology. Am J Obstet Gynecol 128:303-307, 1977
8. Trabin JR, Pearse WH, Carter R: Subspecialization manpower in obstetrics and gynecology. Obstet Gynecol 51:494-498, 1978
9. Willson JR, Burkons DM: Obstetrician-gynecologists are primary physicians to women—II. Education for a new role. Am J Obstet Gynecol 126:744-754, 1976
10. Pearse WH: Doctors and patients in obstetrics and gynecology: The next 15 years. Am J Obstet Gynecol 125:361-367, 1976
11. Douglas GW: Centennial insights. Am J Obstet Gynecol 126:739-743, 1976
12. Lewis JL, Barber HRK, Boronow RC, et al: What's wrong with ob-gyn surgical training?—How can it be upgraded? Con-temp Gynecol 14:78-102, 1979